SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

MARCH 1952

VOL. LVI No. 3

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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March, 1952

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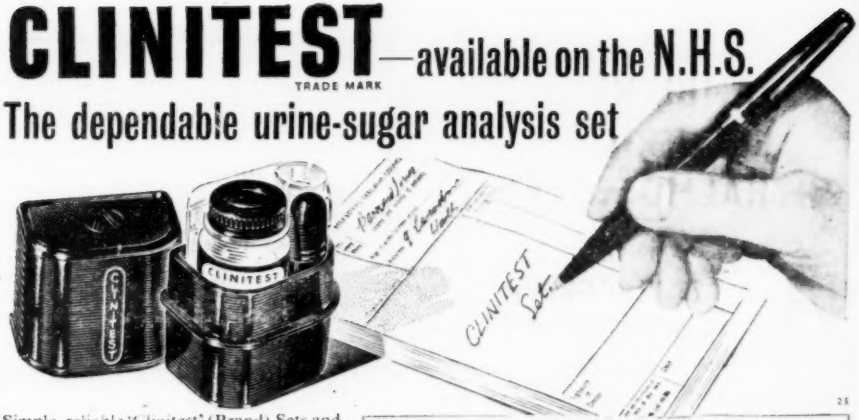

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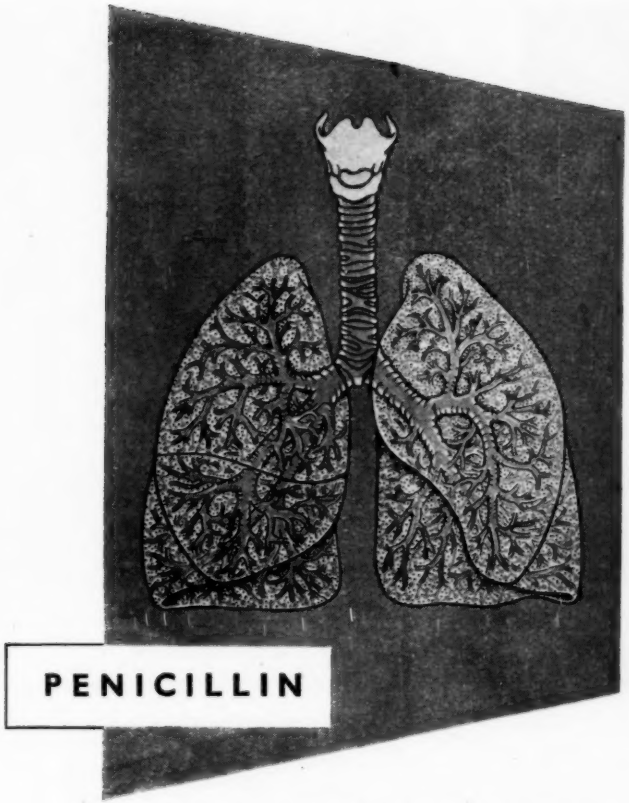

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ST. BARTHOLOMEW'S

HOSPITAL JOURNAL

Vol. LVI MARCH, 1952 No. 3

SIR ARTHUR CONAN DOYLE, M.D.

ON another page of this issue a correspondent makes a plea to Sherlockians to turn their admiration from Holmes to Sir Arthur Conan Doyle. We do not foresee a great success for such a plea, but we agree with the writer that Conan Doyle is indeed pitifully neglected. Without disparaging Holmes and Watson, why should we not admire

"That famous trinity of fact and fiction;
The world of crime together they could foil—
John Watson, Sherlock Holmes and
Conan Doyle."

as did Zeta in our January issue? There is little new to say of Holmes and Watson, so let us concentrate for once on their creator.

Although one might imagine that the placing of the first meeting in our Chemistry Laboratory was a tribute to the author's old hospital, this is not so. Doyle did his medical training at Edinburgh, and there is little evidence that he ever set foot within the walls of Bart.'s. We do not know of any direct evidence, in fact we have found none even so concrete as that for Holmes' presence here. Indeed we are reduced to the vague presumption that Doyle must have chosen Bart.'s for *some* reason—and perhaps the most likely is that he once came here himself.

The Professors at Edinburgh provided Conan Doyle with ideas for many of the characters which were to appear later in his books. Dr. Joseph Bell—a surgeon at the Edinburgh Infirmary—was, according to the author, the prototype of Sherlock Holmes. Dr. Bell himself confessed that Doyle "owes much less than he thinks to me"; but there is no doubt that Bell was the first inspiration and that Doyle enlarged on it as the Holmes saga developed. Other possible sources, one of which Doyle himself acknowledged, were pointed out by Bernard Shaw when he said: "As I was brought up on Dickens' Inspector Bucket, Wilkie Collins' Sergeant Cuff and Poe's Dupin, I thought nothing of Sherlock Holmes." Hesketh Pearson, in *Conan Doyle—His Life and Art*, suggests that Holmes' precise method first appeared in Voltaire's *Zadig*. All these have something of Holmes; but what author can now create a character which is altogether new? New names may owe a debt to their counterparts in the older fiction, or the similarity may be quite fortuitous. The best evidence we can hope for is an honest author's word that it is to so-and-so, or such-and-such an author, that he is indebted. In Conan Doyle there existed a writer who was unusually frank about such matters, and it was Dr. Bell and Poe's Dupin that he mentioned as the sources of Sherlock Holmes.

Doyle records an example of Bell's diagnostic powers that shouts "Holmes" from the housetops:

A new patient was brought before Dr. Bell:

"Well, I see you've served in the Army."

"Aye, Sir."

"Not long discharged?"

"No, Sir."

"In a Highland Regiment?"

"Aye, Sir."

"A non-com. officer?"
"Aye, Sir."
"And stationed at Barbados?"
"You see, Gentlemen," said Bell to his students—among whom was Doyle—"the man was a respectful man but did not remove his hat. They do not in the Army, but he would have learned civilian ways had he been long discharged. He has an air of authority and is obviously Scottish. As to Barbados, his complaint is Elephantiasis, which is West Indian—."

This precision of thought is the part of Holmes that Dr. Bell inspired; the moods, the tobacco, and many other facets of Holmes' private life are much more like Dupin. If they were also like the private life of Bell we should hardly expect Doyle to have known it.

The character of Conan Doyle himself has been many times pointed out as that of Dr. Watson. The character of Holmes is remarkably consistent throughout the stories, but Watson's displays variations—as if Doyle were writing of himself in one story, and of Watson in another. Both Doyle and Watson were under fire in the Boer War. It is tempting to explain the inconsistencies of Watson's wound as being one of Conan Doyle himself and the other of Dr. Watson. Unfortunately there is no record that Doyle was in fact wounded at all! But apart from such idle speculations, the writing reveals real inconsistencies in Watson's character. Thus in "The Red Circle" Holmes addresses Watson, "Ah, yes, Watson—severely practical as usual!"—it might almost be Lady Conan Doyle addressing her husband!—and has little similarity with the following opinion of Watson: "Your fatal habit of looking at everything from the point of view of a story, instead of as a scientific exercise," says Holmes, "has ruined what might have been an instructive and even classical series of demonstrations." Yes, John Watson was indeed a variable character, "severely practical" in one tale and quite unscientific in another. He undoubtedly has something of Conan Doyle as his friends knew him, and perhaps the rest is Doyle as he saw himself: but the identification cannot be complete—

"So please grip this fact with your cerebral tentacle,
The doll and its maker are never identical."
—as Doyle wrote of another matter.

So it is that Dr. Watson has a nebulous character and one which inspires no single picture in the reader's imagination, while Holmes' face and figure are as well known to us as those of the current Prime Minister.

So much for a brief outline of the origins of Sherlock Holmes and Dr. Watson. Not everyone will agree with everything that has been written, nor with all the views which have been expressed.

Although Dr. Bell said that he always regarded Doyle as one of the best students he ever had, Doyle's medical career was not a great success. His first post was as a ship's doctor in 1881, at a salary of £150 a year. After several other jobs, including one in West Africa, and another in partnership with his friend George Budd (who ran a very strange General Practice), he went into practice on his own. He was popular but never succeeded in earning more than a bare living for himself, and later, for his wife. One of his income tax returns showed such a small figure that the inspector wrote "Most unsatisfactory" on it and sent it back to Doyle, who added "I entirely agree" and returned it! His first writings date from this period in General Practice, and as his writing became more and more accepted his medical interest waned. He made one brief attempt at a medical revival, as an ophthalmologist. He trained for a month or two in Vienna, and on his return set up as a consultant. But, in his own words, he had "—a waiting room and a consulting room, where I waited in the consulting room and no one waited in the waiting room." With this light thought he passed from medicine to Sherlock Holmes and Brigadier Gerard. "Not even the Corpus Hippocraticum," said the Lancet at the time of Doyle's death, "with over two thousand years start, has been sold in such profusion as the various volumes in which Sherlock Holmes appears." A worthy tribute to a man who deserves to be remembered as something more than "The Editor of Watson's manuscripts."

The Dorchester Ball

The annual Ball is always an interesting as well as an entertaining event in the necessarily somewhat meagre social life at Bart.'s—its social life is restricted because there is nowhere in the Hospital to hold the smallest hop until the new Charterhouse Square building is open. The entertainment lies in firmly ignoring one's attenuated bank account and for once in a while enjoying the life of the fat and the wealthy and the belimousined. The interest is twofold. It lies partly in seeing who one's friends' partners are. This special occasion, thought of for months and planned for weeks, calls for special partners, and it is indeed interesting to note how the barometer of friendships has changed at short notice and to see that Mavis, an odds-on favourite a few weeks ago, has now relinquished pride of place to Lulubelle. Interest also lies in seeing one's chiefs in new rôles, laying aside the white coats of authority, putting on the tailed jackets of *bonhomie*, and gyrating — some of them very badly round a smooth, polished floor. The senior staff were by no means prominent, but two professors, a well-known physician, an eminent surgeon and a tame psychiatrist were all seen with their hair at least loosened, if not actually down.

Some 300 people enjoyed the Ball very much — your correspondent takes it upon himself to speak for so many. The ballroom at the Dorchester is beautifully furnished, the dance floor is good, the carpets are of thick plush, and the waiters are obsequious. Bill Savill's orchestra played popular hit tunes almost non-stop from 8.30 till 2, and the floor, though full, was never overcrowded. The buffet supper was well up to the high standards of Dorchester cuisine.

But there are also one or two criticisms to make. About three-quarters of all the dances were quick-steps, and after one has danced about five of these, even to tunes taken from "Kiss me, Kate" and "South Pacific," they become a bore. Neither tango nor rhumba was heard the whole night, and there were no more than four slow waltzes. The elimination dance was a farce—surely a little forethought could have found a more amusing way of eliminating couples than hiving them off by corners!

The other criticism is the lack of a cabaret. There is plenty of room for one in a Ball that lasts five and a half hours and costs the price of this one. A cabaret does not mean a costly chorus, but only a little organisation and not much expense. A few unusual songs well sung, one or two comedians, and a sketch suitable to the tone of the evening would provide a most welcome interlude and make the annual Ball a first-class event. It should not be difficult to find the talent necessary for this either in the hospital or among the large number of people connected with, treated at, or interested in Bart.'s.

Vice-President

Mr. F. C. W. Capps has been appointed Vice-President of the British Association of Otolaryngologists for 1952. The *Journal* sends its congratulations to him.

Students' Union

We congratulate Professor Garrod upon his election as the new President of the Students' Union. He takes the place of Dr. Strauss.

Professor Garrod's election created a vacancy for a new Treasurer, to which Professor Blacklock has been elected. The other two treasurers are Professor Cave and Mr. Alan Hunt.

Notice

Mr. C. Naunton Morgan is standing for election to the Council of the Royal College of Surgeons.

Publication

We congratulate Philip Gosse on the publication of his biography of Philip Thicknesse entitled "Dr. Viper—The querulous life of Philip Thicknesse." *Journal* readers will remember that Mr. Gosse was the author of the article in the January issue entitled "Four Humorous Writers from Bart.'s." A review of his book—for which we wish him every success—appears on another page.

Bart.'s Bombsite Garden

Not many people at the Hospital realise that outside the Bart.'s Workshops is a bombsite garden, which must be one of the first of such gardens to be built in London, since it was started well before the war. The death of the workshop cat, Minnie, inspired the original garden, which was planned as a small area of crazy paving but grew to include a birdbath, flower beds and a large rockery. In 1938 the garden was already so famous (such things were rare in the pre-war City) that C. H. Middleton trespassed in a nearby building to get a view of it.

In 1939, with war threatening, some 450 tons of sand (lest sandbags should be needed to protect the Hospital) was stored on the land immediately adjoining the garden. A hoarding was erected to prevent the garden from being quite submerged in sand. In August, 1939, all the sand was put into bags in record time—barrels of beer were provided for the workers—and the garden returned to normal.

During the big air raid of May, 1942, the adjacent buildings were destroyed by a land mine, and most of the wreckage was deposited on the garden. For the remainder of the war no one had time to clear up the mess, and the garden ceased to be.

In 1948 the workshops were to be repaired and it was necessary to put up scaffolding. To do this the debris had to be cleared away, and it became possible to reclaim what was to become our *bombsite* garden. A colossal amount of work had to be done to move and support the debris, and a very ingenious wall of bricks (but no cement) is holding back over six hundred tons of it.

The garden now has a rockery with a pool, an ornamental stand made from an old flower-pot and a dustbin lid, flower beds, and cinder paths, and is on four different levels. Many of the plants have been rescued from the Hospital dustbins, and others have been given by the Hospital gardeners and by the offices which overlook the site.

The whole garden has been built, and is kept up, by three members of the Bart.'s workshop staff, and all the work has been done in their lunch hours. If any of our readers have some of *their* lunch hour to spare they should go and see this attractive garden ; they can be sure of a warm welcome from the Bart.'s Bombsite Gardeners.

College Hall

The new College Hall at Charterhouse Square is now fully open. It was much admired when it was on view last month; and, looking round the building, one received an impression of " style " which has been sadly lacking from post-war Britain. Everything has really been *designed*, and there is no evidence of " We couldn't do that, we hadn't got a licence." One was reminded, not so much of the Festival—for here is something solid and lasting—as of seeing round a great new liner before her maiden voyage. However much the *Journal's* correspondents may disagree about it, *Scandinavian* is the word which will convey the right impression of this building to old Bart.'s men, who have not yet seen it. We say " not yet " because we hope that all Bart.'s doctors will come and see this fine new building. They will not be disappointed.

On behalf of the present and future students here we say thank you to the Medical College for a building which will be the pride of Bart.'s for many years to come.

Medical Spelling

It has been pointed out that the word humorous was twice mis-spelt " humerous " in our January issue. This seems to be an occupational condition, even if it does not quite amount to a disease; the link with humerus must prove too strong for many medical men. No doubt there are numerous examples; for instance, oarsmen often spell the cranium—" scull," while anatomists give scull a " k." Nevertheless we apologise for the mistake.

Wessex Rahere Society

The list of old Bart.'s men living in this area is now sadly out of date. Dr. Charles Wroth has a meeting arranged in Exeter for April 19, and would be glad if any old Bart.'s doctor who now lives in Wessex would communicate with Mr. Daunt Bateman, 3, The Circus, Bath.

BIRTH

JEPSON. On January 16, 1952 at Invercargill, New Zealand, to Joan (nee BLACKLOCK) and Frank—a son, Charles Robert. Both well.

"ON FARING FOREIGN"

by SIR PHILIP MANSON-BAHR. C.M.G., D.S.O., M.D., F.R.C.P.

IT IS difficult for those who have not had any first-hand experience of life in the Colonies to understand what an enormous task confronts the endeavour to raise the standards of health in illiterate native peoples. Civilization spreads very slowly, slower than the stay-at-homes can realise; doctors have to fight famine, drought, poverty, diseases and malnutrition. The majority of natives are, under the best circumstances, living on inadequate and ill-balanced diet, and it is a matter of opinion, whether this does not constitute the background to most tropical infections and render their efficient treatment more difficult to achieve. It must not for one minute be thought that the so-called tropical diseases always dominate the scene, because tuberculosis, venereal disease, helminthic infections, fungus skin diseases, pediculosis and scabies are widespread.

In spite of this statement much progress has been made during the last 25 years. Yellow fever, once the scourge of West Africa, has been fully controlled, and in many places eliminated, whilst malaria has been virtually eradicated from most of its ancient strongholds, so much so that the West Coast of Africa which was formerly known as the "white man's grave" is now regarded by some actually as a health resort.

At present there are in the Colonial Medical Service some 800 administrative, public health and clinical posts for officers hoding a registrable medical qualification. Of these some 50 posts are available for women medical officers. There is also a large auxiliary force of locally-trained doctors and medical orderlies.

There are opportunities for men with higher qualifications which have been approved for the purpose of qualifying for appointment as Special Grade Medical Officers such as F.R.C.S., M.R.C.P., M.R.C.O.G., and for those with diplomas in ophthalmology, psychology, bacteriology, clinical pathology, medical radiology, public health, and anaesthetics.

Successful candidates would enter the Medical Officers' salary scale with £1,050 per annum rising to £1,590 per annum in East, or £1,060 to £1,600 in West Africa and, in addition, they receive increments in respect of war service and approved professional experience. The salary scale in Malaya is from £1,120 to £1,652. In most countries higher salaries than these are paid to men on short-term appointments.

Recently a scheme has been drawn up for the employment of doctors from the National Health Service in the Colonial Medical Service. The primary object of this scheme is to enable doctors to join the Colonial Medical Service for temporary periods without loss of pension rights within the National Health Service superannuation regulations. The scheme applies especially to those Medical Officers who, within 12 months of ceasing to be employed by a Regional Hospital or Board of Governors of a Teaching Hospital, should seek to join the Colonial Medical Service. The doctor who accepts this will be required to serve for such period as may be arranged for one, two or three tours up to a maximum of six years in all.

For superannuation purposes he would continue to participate in the National Health Service Superannuation Scheme. The contributions payable are based upon his Colonial salary, whilst the Colonial government would pay the employer's share of contribution, i.e. 8 per cent. of Colonial salary. The doctor so employed will be eligible to transfer permanently to the Colonial Medical Service, on transfer to the service payment of contributions under the National Health Service would cease. Service which is pensionable under the N.H.S. Superannuation regulations would be regarded as qualifying for Colonial Pension. If the Medical Officer elects to re-enter the National Health Service on expiration of his period of service in the Colonial Medical Service for which he is engaged, he will be granted 20 per cent. of the aggregate of his salary during his period of service to the Colonies.

In spite of our somewhat over-generous Colonial policy of the last few years there

still remain a number of countries which require the services of British Medical Officers. In the Mediterranean, where the climate is salubrious and there are many historic and cultural attractions, there is Gibraltar and Cyprus where you can always eat oranges and lemons to your heart's content. The climate is in the main temperate ; in summer the maximum temperatures range from 83° F. to 85° ; but from June to August it is practically rainless. There is little indigenous disease and no malaria or typhoid.

Cyprus is still one of the cheapest resorts in the world. The climate is ideal so that women and children can remain permanently on the island. There are very numerous opportunities for sport, for shooting, fishing, and even for skiing. As the result of the recent anopheles eradication campaign there is no danger any longer of being infected with malaria.

Africa is hot, in parts dry and dusty ; in others steamy, soggy and wet. You cannot expect otherwise. You can be very hot indeed in Central Africa ; you can just be cool, but also you may freeze. With such a range, in such a vast continent, we have much to choose from. Aden guards the gateway to Africa and Arabia. It is, it is true, hot, dry and dusty. Camels and smells abound. There are those who actually enjoy them.

East Africa is a white man's country and in times like these is the focus of attraction for many. The climate is, of course, tropical, but is modified in many ways. It differs according to the elevation between the coast and the Central Plateau.

The highland area (5,000 to 10,000 feet) with cold nights, and occasional frosts, provides a bracing climate, ideal for Europeans.

Colonial War Memorial Hospital at Suva, Fiji Islands.

For those who like the wide open spaces, let me recommend N. Rhodesia. Although it lies between 8-18° south of the Equator, its elevation robs it of the unpleasant high temperatures and humidity usually associated with the tropics.

During the winter months — May to August—fair, cool weather is the rule and ground frost is not infrequent.

Nyasaland—a land of lake and mountain —where tea and coffee grow, has been a bit of a Cinderella amongst its larger neighbours ; but it has its attractions and medicine there is varied and interesting. The climate is similar to that already described above.

West Africa has certainly had a bad reputation and this it consistently maintained, until some 40 years ago. Now as the result of the newer antimalarial drugs and antimalarial measures, together with improved hygienic conditions and a more sensible outlook on the part of Europeans—the discarding of antiquated notions about sunhelmets and clothing—and most of all, by the introduction of the motor car and the frigidaire, the outlook has improved beyond recognition. Now European women and children reside in the Gold Coast as well as in Nigeria and Sierra Leone for a year and even longer without any recognisable deterioration of health, but children should not remain after reaching the age of six or seven. Opportunities for sport naturally vary in different stations, but tennis is usually available and there is excellent bathing in some resorts on the coast.

Mauritius is an island in the Indian Ocean, the ancestral home of Paul and Virginia and the Dodo, though situated within the tropics, it has a particularly even temperature, but is subject from time to time to tropical cyclones. Mauritius is the typical example of the ideal healthy tropical paradise which was ruined by the introduction of malaria from the mainland of Africa nearly 100 years ago. Now the island is rapidly regaining its reputation as a tropical health resort as the result of the application of D.D.T. on a large scale.

Further north lie the Seychelles which are seldom visited by the tourist, but which are extremely beautiful and healthy and, considering their proximity to the Equator, enjoy an agreeable climate. In the South Atlantic lies the Island of St. Helena, where lay the tomb of Napoleon and which was so tragically connected with the closing years of this historic phenomenon. The climate there is mild and healthy with temperatures ranging between 46°F. and 86°F.

In the vast Pacific a number of islands are staffed by British Medical Officers. The most important are the Fiji group and these are in the Western Pacific where the climate is healthy and there are no anopheles mosquitoes and, consequently, no malaria. The rainfall is heavy, averaging 120 ins. in the wet zones and about half of this in the dry. The Polynesians are a fine, upstanding race, who have taken to cricket and rugby football, like ducks to water, and their relations with the British have always been co-operative and friendly. The climate is suitable for most Euopeans. The average maximum temperature is 82.5°F. and the average minimum 71.5°F.

To the north-west of Fiji and in the same administrative area lie the British Solomon Islands, but the heat and humidity are considerably greater and exert an enervating effect upon most. These islands are fortunate in lying outside the hurricane belt and the coconuts flourish on a large scale. For those who enjoy a Crusoe existence amongst coral reefs, palm trees and lagoons surrounded by friendly and attractive people the Gilbert and Ellice Islands can be recommended.

Far in the South Atlantic, bordering the Antarctic seas lie the Falkland Islands where conditions are very different indeed. This is the land of seals and penguins and the temperature is low, ranging from 40°F. to 65°F. in summer, and from 30°F. to 50°F. in winter.

In the West Indies the, climate is, of course, tropical but very favourable on account of the cooling effects of the N.E. trade winds, so that even in the hot season the temperature rarely rises above 93°F. The rainy season sets in about June and lasts till the end of the year. In the Bahamas malaria is practically non-existent. In these islands which make an ideal winter resort, the climate is delightful with an average of 70°F. Barbados has a reputation for health and the climate is equable and cooler than its proximity to the Equator would suggest.

Beautiful Bermuda is well-known as a millionaire's playground. The climate is healthy ; malaria is absent and it is particularly agreeable without extremes of cold or heat. The summer season—July to September—is enervating.

Souffriere Hospital and Health Centre at St. Lucia, Windward Islands.

Up till the last few years British Guiana, where the sugar comes from, had an unenviable reputation for malaria, but this has receded almost to the point of extinction, by spraying with D.D.T. The heat on the coastal plain is tempered by sea breezes and the maximum shade temperature rarely exceeds 85°F. or falls below 73°F. on the coast. Nearby lies British Honduras, the forgotten colony, the headquarters of Chicle from which the chewing gum of the Americas springs and the home of mahogany. There the conditions are similar to the West Indies.

Jamaica possesses, apart from the occassional hurricane, an ideal climate, for it is hilly and in parts mountainous. The mean temperature of Kingston is 78.7°F. rising to 87.6°F., but falling to 71°F. in the early mornings. The Leeward Islands comprise Antigua, St. Christopher and Nevis, Montserrat, Trinidad and Tobago. Here, too, the climate is delightful from the end of November to May. After this the trade winds peter out and the rains set in. Trinidad, the home of asphalt, has a slightly warmer climate and the night temperatures average 74°F. In the Windward Islands—Dominica, Grenada, St. Lucia and St. Vincent, the climate is pleasant from December to May. From July to the end of October there is greater humidity. Malaria still exists, but is minimal.

On the other side of the world there is fertile, prosperous Malaya where the climate is particularly healthy for a tropical country, though the range of temperature is small, varying between 86.8°F. to 74.3°F. In most parts there are no marked rainy or dry seasons, but in some there are a couple of dry months. The average rainfall is about 100 ins., so that the vegetation maintains an intense green colour. European children do well up to the age of six. The saving grace are hill stations situated from 2,000 to 4,000 feet.

Hong Kong, that busy and most important emporium, is favourable to Europeans, for there is a cool, dry winter and a well-marked seasonable change, though the summer is trying on account of the humidity, the temperature rarely exceeds 98°F. From November to March the climate is well-nigh perfect with temperatures from 35°F. to 80°F. Children can remain in the colony until they are eight or nine years old.

The climate of North Borneo is tropical and equable, varying from 70°F. in early morning to 88°F. at midday. The nights are cool—about 70°F. Typhoons are unknown. Malaria, until recently, was widespread.

Sarawak is now controlled by the Colonial Office. The climate is healthy and resembles that of North Borneo. It has also the advantage of cool nights which induce blessed sleep. The annual rainfall in Kuching, the capital, is 130 ins. The N.E. Monsoon blows from October to March.

You may want to know in what directions you could make yourself more useful and how you could undertake any original work. For the clinical observer there is still an immense field in what is best known as "geographical" pathology—that is the incidence of various diseases and their apparent predilection for certain races of mankind. In this category we can place pernicious anaemia, nutritional anaemia, chlorosis, Cooley's anaemia, sicklaemia and the various forms of leukaemia. Then there is the influence of diet and habits on various races on the incidence of peptic ulcer, appendicitis, diverticulitis and carcinoma. Why is coronary thrombosis so rare among native races living under primitive conditions, and why is primary hepatic carcinoma relatively so common in Africans? What is the true etiology of cirrhosis of the liver in Mohammedan races, and in whom alcohol can play no part? What are the various types of steatorrhoea in tropical races?

A new disease of childhood — malignant malnutrition (*Kwashiokor* of Cicely Williams) appears to be extremely common, is there a peculiar distribution which might shed some light on its essential cause?

A comparatively new entity is tropical eosinophilia or pulmonary eosinophilosis. What is its incidence and distribution?

In the field of cardiology, there is an immense amount to be done.

These are some of the questions which might attract the general clinician. But to make a contribution to scientific tropical medicine entails the special study of the triad, protozoology, entomology, and helminthology, and all of them immense subjects in themselves. That this special training is bearing fruit is shown by the number of really fundamental discoveries that have been made in recent years.

And so in this strain it would be possible to continue *ad infinitum*. To the wayfarer to tropical lands I wish "good hunting" with the hope that his steps may lead him down as many pleasant and interesting pathways as those of the writer of this article.

EXAMINATION RESULTS

CONJOINT BOARD

Final Examination

Pathology — **January 1952**

Bartley, R. H. — Harries, E. H. L. — Ryan, J. F. — Waddy, G. W.
Dickman, H. R. — Middleton, G. W. — Sarma, V. — Watkins, D.

Medicine

Batey, I. S. — Goode, J. H. — Parker, R. B. — Todd, J. N.
Blake, A. S. — Goodspeed, A. H. — Power, G. H. D'A.
Channon, C. E. — Husainee, M. M. — Stoke, J. C. J.

Surgery

Beale, I. R. — Hall, M. C. — O'Reilly, P. B. — Wynne-Jones, A. P. J.
Channon, C. E. — Heckford, J. — Parker, R. B.
Cookson, T. S. — Ladell, R. C. H. — Rosser, E. M.

Midwifery

Dodge, J. S. — Ladell, R. C. H. — Lewis, J. A. — Parker, R. B.

The following students have completed the examination for the Diplomas M.R.C.S., L.R.C.P.:—

Blake, A. S. — Husainee, M. M. — Parker, R. B. — Rosser, E. M.
Channon, C. E. — O'Reilly, P. B. — Power, G. H. D'A. — Waddy, G. W.
Goodspeed, A. H.

UNIVERSITY OF LONDON

Special First Examination for Medical Degrees. — **December, 1951**

Grassett-Molloy, G. J. M. — Thomas, A. D. M.

The following External Candidate has completed the Internal First Medical Examination.

Ramsden, R. A.

The following Higher School and General Certificate of Education Candidates have qualified for exemption from First Medical.

Barfoot, P. W. — Butler, A. C. — Costley, S. R. — Freestone, D. S.
Thom, B. T.

DEATHS

Dr. W. H. Square

A Correspondent writes:—

Shortly before last Christmas and a few weeks after his ninety-first birthday, Dr. W. H. Square died at his home in Bedfordshire. It is believed that he was the oldest practising doctor in the country and two years ago he had said that he was the oldest Bart.'s man in practice. He was born in 1860, qualified in 1884 and spent sixty-seven years in general practice—over fifty of them in Leighton—ceasing to work only a few days before his death.

A stranger meeting him some months before he died was at once arrested by the alertness of mind and activity of body of a man of obviously great age. His tall thin figure, erect carriage, trim beard and Edwardian dress made an unforgettable picture. A visit with him to the cottage of a widow of the first world war whose daughter was seriously ill revealed clearly his important place in the life of the community which he served as well as a depth of feeling which a long and intimate experience of suffering could not diminish. It seemed, too, that he had remained a student throughout his life, for he had a good knowledge of relatively recent advances in medicine.

In meeting such a very old Bart.'s man it is natural to wonder about the Hospital as he knew it. Among the physicians of those days were Drs. Southey and Gee; the surgeons included Messrs. Holden, Smith and Willett; Dr. Matthews Duncan was physician accoucheur and Mr. Harrison Cripps the surgical registrar. Outstanding among Dr. Square's student contemporaries were W. Herringham, T. W. Shore, F. W. Andrews, A. Garrod, A. Bowlby and J. Berry. Several of these have by their labours added to the reputation of their hospital. It must surely be that the long life of service of their less well-known contemporary has done likewise. In addition his life indicates with particular clarity the importance of the general practitioner's contribution; his personal relationship with perhaps several generations of his patients gives an insight into their complaints which others will frequently lack; his ever-growing experience of illness in all its forms and in the home is a basis for true medical wisdom; and in addition with the coming of old age his value to the community may remain undiminished.

J. E. A. O'C.

Lt.-Col. Hugo

Lt.-Col. Edward Victor Hugo died recently after a short illness. He was a medical student at Bart.'s in the eighties and graduated M.B., B.S., in 1890, with Honours and Gold Medal. He left Bart.'s for the Indian Medical Service in 1892. He was mentioned in dispatches for his work on the North-West Frontier in 1898, and was appointed Professor of Surgery at King Edward's Medical College at Lahore, in 1908. This post he held until 1922, with a break for the first World War during which he resumed his military duties, and was made a C.M.G. in 1917. Col. Hugo married in 1909 and his widow survives him. We offer her our deepest sympathy.

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* Reprints received and herewith gratefully acknowledged. Please address this material to the Librarian.

THE TREATMENT OF ACUTE APPENDICITIS

by HARRY KARN

Dunedin Hospital, New Zealand.

THE object of this article is to recapitulate briefly the clinico-pathological features of Acute Appendicitis, to demonstrate the lines of treatment, and to outline certain points in the technique of Appendicectomy that may prove of value to those to whose lot the operation falls but occasionally; those practising in outlying areas inaccessible to major surgical centres, the Ship's Surgeon, and finally to House Surgeons embarking on the operation during the early stages of their career.

Appendicitis, as a disease, will continue to tax the ability of the Medical Profession. It shows no abatement in its case incidence and continues to exact an annual mortality rate in New Zealand of about 50 persons. It is now apparent that, after 50 years of skilled surgical intervention, there has been a sustained fall in the mortality rate—the figure has been nearly halved since 1940.

In any hospital serving a population of 50,000 and over, it is rare not to have a case admitted within the 24 hours of any one day: few nights pass without the resources of a busy operating theatre staff, and already tired surgeons and residents, being called upon to perform an emergency Appendicectomy.

Operation follows diagnosis—

Age is no contra-indication to operation, concurrent pregnancy makes operation imperative. The object to be achieved is Appendicectomy: the removal of an intact organ before either bacterial seepage or perforation have given rise to Peritonitis. It is by no means a minor procedure, and those embarking on it must be prepared to encounter and possibly deal with any of the conditions in the "Acute Abdomen." The successful extrication of an intact organ may demand a great amount of skill and careful judgment, yet for the small amount of trauma the result in most cases is the most gratifying of any abdominal operation

In the long run it does not matter who performs the operation, figures collected from different centres appear to equalise out all round; what does matter is the individual diagnosing the acute abdominal condition as Acute Appendicitis WITHIN THE FIRST 24 HOURS—be he patient, relative, friend, general practitioner, physician or surgeon—admission to hospital must follow without delay.

Hour by hour, day, by day, the mortality rises with the march of pathological processes. Experience shows that general peritonitis is rare within 24 hours of the onset of symptoms, eradicate therefore all cases of 24 hours duration and over and the mortality rate should then fall to that of the surgeon's capabilities.

The symptoms are fairly clear-cut: yet, for the delay, the pitfalls are many; the mode of onset can give no clue as to the probable state of affairs 24 or 48 hours hence. *Delay, purges and enemata court disaster.* How often has the surgeon castigated the dose of Castor Oil traced as the cause of the perforated Appendix; yet he also suffers the humiliation of removing an intact and normal organ when he has embarked on, what is colloquially termed, a "true bill" case. In spite of this, there must be no exception to the rule, that all cases admitted to hospital and then diagnosed by the surgeon as Acute Appendicitis, be subjected to operation as soon as possible, even though the symptoms are six hours from the onset and the hour is midnight. The disease is possibly still confined to the organ, peritoneal disturbance is minimal, and the outcome will be one of full recovery with a smooth convalescent period.

To quote from page 60, "The Statistical Study of Appendicitis," by Young and Russell, a pamphlet published in 1939 by the Medical Research Council (Special Report Series No. 233):—

"Figures need great scrutiny, but for Peritonitis it (the mortality rate) goes up to 30 per cent. or more depending on the time interval elapsing between the onset of symptoms and either admission to hospital or operation. Although the real advantage to be gained from early operation is probably not represented accurately by these fatality rates, because the comparatibility of the groups at different intervals is doubtless impaired in some degree by circumstances that result in the selection of cases, there is convincing evidence that early admission to hos-

pital is one of the most potent factors in reducing the mortality of Appendicitis. Bowers in 1934 made an overall study of 15,000 cases:—

In 24 hours the mortality rate is 2%
In 72 hours the mortality rate is 9%

It would appear that the only hopeful method of further reducing the fatality of the disease is to encourage, by the education of the public, earlier entry to Hospital and avoidance of purgatives and laxatives."

Based on an intensive analysis of all cases of Appendicitis admitted to the Dunedin Hospital over a continuous period of twelve months, I came to the conclusion that there are three major sources of delay in the operative treatment of the cases.

Sources of delay in diagnosis.

(*a*) THE PATIENT. He misdiagnoses the condition and delays the request for medical aid.

(*b*) THE GENERAL PRACTITIONER. Misdiagnoses the condition and fails to send the case to hospital for operation.

(*c*) THE SURGEON. Misdiagnoses the case after admission to hospital and delays operative intervention.

(*a*) *The Patient.*

This is the largest group, and it is dependent upon several factors, among them being the fear of operations, and the human tendency to procrastination. Intestinal upsets are common, the "gastric 'flu" is a satisfying household diagnosis, and the calls of everyday duty or the pressure of urgent business cannot be delayed by sudden illness. Some dietary indiscretion is blamed: as the day progresses the full classical syndrome appears; the severity of pain and vomiting depending on the underlying progressive pathology in the two groups (*a*) Catarrhal, or (*b*) Obstructive. The day's work is done, night draws nigh, and after the household retires the patient appears to become more conscious of the severity of the pain. In an estimation there is a delay of up to eighteen hours, in the majority of cases, before a doctor is called in for consultation. Some hope to avert the disease by starvation, hot fomentations and bed. Others take a purge —the dangers increase with each hour of delay. On close examination of statistics the highest overall mortality figures lie between the ages of 5—15 years. The child either delays reporting the illness, or is helpless against the parents' or guardians' administration of purgatives—the "cure-all" for any intestinal colic. The liability resting on persons in such cases is high. Professionally we are powerless to prevent this, and can only hope to avert these disasters by continued propaganda.

Fatalities to children due to vehicular accidents are headline news, those due to purgatives warrant no comment.

(*b*) *The Medical Practitioner.*

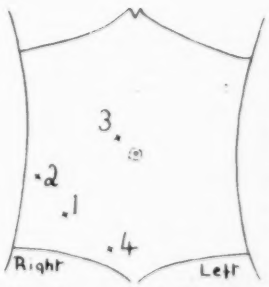
Appendicitis, as a disease, varies both clinically and pathologically, fallacies appear in diagnosis: the same case seen hours later may present different signs. If, then, Appendicitis enters into the differential diagnosis, admission to hospital for observation is the only rational treatment.

The Early Symptoms and Signs

If these were clarified, from the point of view of the individual making the FIRST examination and diagnosis, there should ultimately be no mortality rate.

The casual reader may think that all this is unnecessary. The literature on the disease, recorded by the greatest and most competent of surgeons, is readily available in all the standard textbooks. In spite of all the accessories to investigation, a thorough history and careful clinical examination are the first essentials in diagnosis. I would apologise for recapitulating and stressing certain points.

A careful HISTORY is an absolute necessity. Time spent in eliciting a chronologically correct story is time well spent. It can be taken as a safe guiding rule that in a FIRST attack the pain never commences in the R.I.F. Recurrent attacks are common.



1. Pre-Ileal. R.I.F. The classical McBurney point.
2. Retro - Caecal. Right Loin.
3. Sub - Hepatic. Para-Umbilical.
4. Pelvic. Suprapubic and Rectal.

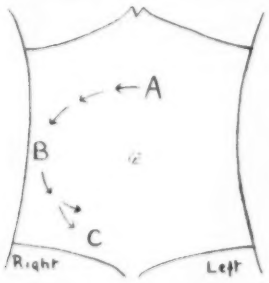
The Anatomical Positions of the Appendix.

In a first attack of the disease the pain is usually sudden in onset. One may accept the "bolt from the blue" description of a generalised central abdominal pain in an

otherwise healthy individual, often waking him from his sleep in the early hours of the morning. Vomiting usually accompanies this heralding attack of pain. There may be no rise in temperature or pulse rate.

As the disease progresses the pain travels to reach, and remains fixed, in the R.I.F. with certain variations depending on the anatomical situation of the inflamed organ.

Evidence of toxaemia—rising Pulse Rate and Pyrexia are apparent within 24 hours. Increase in vomiting and persistence of pain complete the clinical syndrome.



A. Central Pain goes via B. to C. —Right Iliac Fossa.

The Radiation of Pain in Appendicitis.

Three Clinico-Pathological Entities can be Recognised.

1. *Catarrhal Appendicitis.*

Causation. Dietetic.
Secondary to Gastro-Enteritis.
Metastatic selective bacterial action in Specific Diseases—Tonsillitis, Influenza, and the Exanthemata.

Clinically the pain is generalised, localising later. Toxaemia and constitutional symptoms appear early.

2. *Obstructive Appendicitis.*

Causation. (*a*) Outside organ.
Congenital bands.
Adhesions secondary to previous attacks.
(*b*) In the wall of the organ.
Fibrosis secondary to previous attacks.
(*c*) In the lumen of the organ.
Faecoliths.
Neuro-muscular incoordination.

Clinically the pain is more colicky and associated with vomiting. At first no marked constitutional reaction, but the condition may pass rapidly on to Catarrhal inflammation, Perforation with sudden relief of pain, progresses after a dangerous silent period to the stage of Peritonitis.

3. *Peritonitis.*
Perforated Appendix.
Localising Abscess formation.
Generalised Peritonitis.

Clinically the Constitutional picture is one of increasing Toxaemia. Pyrexia, rising pulse rate and vomiting.

The differential Diagnosis.

A detailed discussion on the differential diagnosis is not within the scope of this article. A short list of the COMMONER conditions is added :—

IN CHILDREN
Mesenteric Adenitis.
Gastro-Enteritis.
Right-sided Pyelitis.
Right-sided Basal Pneumonia.
Prodromal stage of Exanthemata and Poliomyelitis.

IN ADULTS
Gastro-Enteritis.
Right-sided Pyelitis, Ureteric and Renal Colic.
Cholecystitis.
Perforated Duodenal Ulcer.

IN FEMALES
Ectopic Gestation.
Torsion of Ovarian Cyst.
Salpingitis.

It may be noted how often

(*a*) The RETROCAECAL Appendix is misdiagnosed as Pyelitis or Ureteric Calculus, in adults.

(*b*) The PELVIC Appendix is misdiagnosed in children as Gastro-Enteritis. The diagnosis is decided by eliciting Rectal tenderness. Delay in operating on children is fraught with danger, if there is the slightest suspicion, then laparotomy is the safest procedure.

(*c*) *The Surgeon.*

Some cases may reach Hospital with a doctor's letter specifically mentioning pain and tenderness; this may not be elicited on examination. It occasionally happens that the case is being seen in a "silent" stage, commoner with the Obstructive types of Appendicitis. In uncertain cases the outside doctor should be contacted personally for further confirmatory information; if there is abdominal tenderness the case should be admitted for at least 24 hours close observation. One "Appendix for Observation" admission is preferable to one perforated Appendix misdiagnosed.

Some Operative Details.

The cause of a death resulting from Appendicitis should lead to serious enquiry as to the exact causation, for in spite of everything gaps appear in case diagnosis and the final fall in mortality rests with surgical technique. It is a duty to watch, observe and criticise our own figures.

Our primary aim is the removal of an intact organ without the soiling of the general peritoneal cavity. In cases of established Peritonitis, efficient drainage and toilette of the peritoneal cavity, followed by procedures to combat Paralytic Ileus, and prevent the formation of Residual Abscesses—Pelvic and Subphrenic.

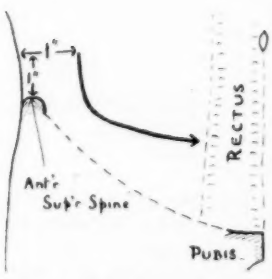
In " Bad Risk " toxic cases with extensive Peritonitis, drainage under local anaesthesia is the only possible line of operative therapy.

1. *The use of supplementary LOCAL ANAESTHESIA.*

After induction with general anaesthesia, the Ilio-inguinal, and Ilio-hypogastric nerves, are infiltrated with a 1% solution of novocaine. The lateral sheath of the right Rectus Abdominis muscle is infiltrated from the level of the Symphysis Pubis to the Umbilicus.

Part of the procedure can be performed through the muscle layers once the incision has been made. This greatly facilitates the muscle retraction in the Gridiron incision and aids in the delivery of an intact Appendix.

2. *The use of the modified McBurney Incision.*



The Modified McBurney Incision.

Commences about 1 inch proximal and medial to the right anterior superior iliac spine curves medially towards the mid-line and follows a crease in the skin. It can be extended medially by incising the lateral edge of the Rectus sheath for the exposure of a pelvic appendix ; it can with ease be extended proximally into the loin to expose a Retrocaecal appendix. In the hands of many surgeons this incision has never failed them in locating and removing an intact appendix, in any of the anatomical dispositions.

3. *The importance of adequate exposure.*

Where the appendix is tense, bound down by adhesions, or the extremities ill-defined, as in the retrocaecal or deep pelvic positions, there should be no hestitation in extending the incision to gain adequate exposure. A long scar, through which an appendix is removed, is preferable to a small one through which an appendix is removed in pieces, or burst during manipulations. It is often technically simpler to remove a deep pelvic, or long retrocaecal appendix by the Retrograde method. Neither clamps nor direct tension should ever be applied directly to the walls of the Appendix: it is surprising and annoying to find how readily the tense organ can burst during manipulations.

4. *The whole Appendix is delivered.*

Lane's forceps hold up the Ileocaecal angle and the mid-appendix, a mosquito or small artery forceps is applied to the tip of the free end of the Meso-appendix.

Two moist small packs are insinuated carefully between the parietal peritoneal edges and the fully exposed meso-appendix, caecum and terminal ileum, so as to isolate the inflamed appendix by means of a pack " barrage " from the general peritoneal cavity.

The vessels in the meso-appendix can often be visualised by the reflected light in the operating area ; they are clamped off in pairs so that in cutting across them a minimum of blood, likely to contain bacteria, is shed into the open wound. In cases with a thick, fatty mesentery it is advisable to grasp the vessels in toothed Kocher forceps and transfix them with catgut on a round-bodied needle.

As the inflamed organ is progressively delivered it is wrapped around in a moist swab, should it then perforate during the manipulation, the contents would spill extraperitoneally into the protective swab " barrage." A sucker should always be available.

5. *Drainage.*

" If in doubt—Drain," remains a wise axiom. If not intra-peritoneally, then at least down to the peritoneum.

Avoid the use of thick drains. Penrose tubing, oiled silk, or glove-rubber dam loosely packed with a wick gauze ("cigarette" type of drain) are most efficient, they do not press on coils of bowel, and are readily removed. In cases with extensive Peritonitis it

is well worth adopting the Mickulicz-Gibson pack drainage. The wound is left wide open, except for some holding tension sutures, and secondary suture is performed later.

It is advisable to subject swabs of the pus to examination for the presence of both anaerobic and aerobic organisms. Tests should be done for their sensitivity to Penicillin, and the Sulphonamide group of antibiotics. There is much work yet to be done on the bacteriology of appendicitis ; in some severely toxic cases there is obviously a mixed bacteriological flora, the newer antibiotics of the Streptomycin group might prove valuable adjuncts to chemotherapy.

6. *Peritonitis.*

Cases presenting clinically with peritonitis may be given a prophylactic dose of Penicillin pre-operatively ; it may be noted that such cases bleed readily, this may be secondary to the haemolytic action of the organisms responsible for the disease ; the administration of Vitamins C and K may diminish this action.

Prophylactic measures in the form of continuous Gastric syphonage by the Wangenstein technique, and intravenous replacement of fluid should be established at the time of operation, to prevent and treat the complication of Paralytic Ileus. These procedures, combined with the post-operative administration of Penicillin and the Sulphonamide group of drugs have noticeably halved the mortality rate in the last 10 years.

7. In uncomplicated cases the patient is allowed up on the day following operation. Pulmonary Embolism as a post-operative complication is a rarity.

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INTERCURRENT ILLNESS IN PSYCHIATRIC DISEASE

by Dr. Louise Rose

The term psychosomatic is now a commonplace, although the name itself may actually obscure the simple fact that no person mentally ill can avoid some somatic manifestation, and vice versa.

In the treatment of psychiatric illness, but more particularly in the day-to-day management of milder forms of neurosis, one becomes familiar with the general personality-picture of the individual concerned and relates clinically the sign—and symptom—complex to the personality presented.

Assuming that a psychiatric disability has been diagnosed, and suitable treatment and management adopted, there is usually a somewhat lengthy period of contact between the patient and doctor, during which time new signs and symptoms may appear and old ones may alter or disappear. It is this impact of new symptoms against which one must constantly be on guard, because there is no reason why a patient with a psychiatric illness should not suffer from a new intercurrent disease. One need not stress the

undesirability, in the pressure of a clinic or consulting room, of reassuring, without adequate consideration, the sufferer that his new visual disturbance or unsteadiness or headache or such-like, is "just another part of the nerve trouble." It is not simply that one must be a reasonably competent clinician, but rather that one must have the attitude towards clinical assessment which will make it possible for doubt to enter into one's mind as to whether the new symptom or sign presented may not, in fact, herald a new disease-entity. One must be able to ask whether the new symptom is compatible not only with the original diagnosis, but with the personality of the subject. In any case, one must be prepared not to waive the complaint aside on the assumption, without due examination of the facts, that it "belongs" to the original illness. A few cases in point:—

Mr. B., aged 54, an engineer, suffered from a mild anxiety state for a number of years; the symptoms included the usual various and variable tremors. At first interview he complained of recent faulty balance, unsteady gait, slurred speech, difficulty with writing, etc. Examination of the central nervous system revealed positive evidence of cerebellar degeneration which has steadily progressed while the psychiatric condition has improved.

Mr. F., aged 53, an architect, had had two depressive episodes about the ages of twenty and thirty (one severe) and was first seen in hospital, semi-comatose with secondary impairment of all intellectual function, apathy, faulty habits, etc., able to reply in a whisper to simple direct questioning. On the personal and family history this was likely to have been a severe depressive stupor, but confirmatory evidence was sought by narco-analytic probing before organic disease could be ruled out sufficiently to warrant electroplexy. The central nervous system was found to be intact on routine examination. No clear psychiatric diagnosis could be made and observation continued. Death supervened in a few days, revealing *post mortem* a large frontal tumour.

Mr. B., aged 72, a retired violinist of somewhat hypochondriacal personality, a frequent attender at his doctor's rooms. He complained of weakness in the legs and some unsteadiness of gait in addition to his usual symptoms of "rheumatism" in the back and joints. Although not actually examined for many months, he was referred to a Rheumatism Clinic for physiotherapy, where a nurse (if you please) suggested that he obtain further advice. He was by that time severely handicapped by the progress of sub-acute combined degeneration of the cord, but now, three years later, is maintained in good general health by routine monthly treatment.

Mr. T., aged 38, labourer, was referred for opinion concerning the poor response to rehabilitation (active and passive) of the right hand following injury at work. His complaint of inability to use the hand, and of weakness in the arms and shoulders was thought to be hysterical, motivated by the compensation factor.

Examination (*with his shirt off*) revealed typical wasting and fibrillary tremors in the muscles of the shoulder girdle, indicative of progressive muscular atrophy.

Miss N., aged 30. A recurrent depressive suffering from episodic palatal phonation thought to be an hysterical superaddition although in no way compatible with the depressive illness, which responded satisfactorily to electroplexy. The vocal disability remained and proved to be the first symptom of myasthenia gravis, episodic ptosis and dysphagia having supervened.

This is not a matter of diagnostic acumen because it is assumed that the competent physician will always be able to reach an adequate diagnosis when he has investigated the problem. The secret lies in the *attitude* which will allow of the necessary orientation towards examination and understanding of the personality and symptom-picture as a whole, so that if the new symptom does not fit in comfortably and obviously, the patient, *as a whole* should be re-examined with a view to deciding the correct place of the new picture in the old frame. This is not to say, of course, that hysterical symptoms should be reinforced by frequent unnecessary examination; on the contrary. The examination should be conclusive—but the conclusion must follow logically on the facts. New illnesses will not in this way be missed and mistakes of diagnosis and treatment will be avoided.

This subject was presented at a clinical discussion of the Bart's Department of Psychological Medicine under the title of "Multiple Pathology in Psychiatric Illness." The present title was suggested by Dr. E. B. Strauss, Head of the Department.

THE WIND-SPRITE

by E. A. J. ALMENT

It is a good and constant thing,
The friendliness of weather ;
Like meeting at the little inn
When reminiscences begin,
And strangers talk together.

Of all the ways that come to mind
Old memory's soft pretences,
The sudden motion of a breeze
Among the great slow-growing trees
Most strongly wakes the senses.

At midnight when the city's dead
An empty, fretful flutter
Strays idly round my ringing feet
And stirs the litter in the street,
And dies along the gutter.

High on a barren Wiltshire down
Where often I'd go ranging
The steady singing rhythm flows,
In waves across the grass it goes,
With light and shadow changing.

It whispers through a Cotswold vale
When summer's day is sleeping ;
Steals where a cottage chimney smokes
And flat among the nearby oaks
It sends the vapour creeping.

The wind that sits upon my sail
Along the Beaulieu river
Makes water-patterns all aslant
Like fingers of an aery giant,
And mast and rigging shiver.

The wild blast of the Norfolk coast
Of all my friends is dearest ;
Across the marsh their cry is borne
As duck come high and fast at dawn,
And I shall miss the nearest.

CORRESPONDENCE

CHARTERHOUSE SQUARE ARCHITECTURE

To the Editor,
St. Bartholomew's Hospital Journal.

Dear Sir,

May we reply to the strictures on our architectural knowledge implied in Mr. Barleycorn's courteous letter. He is indeed a veritable Argus—he has a hundred eyes—but should beware soothing music, particularly that of his own eloquence.

It is especially strange that Mr. Barleycorn sees fit to dispute our appraisal of textile patterns, particularly as we were given a private view of samples and not the finished products, which are still being made. It also seems obvious even to a minor intelligence that a building conceived four or five years ago could not possibly owe any allegiance to last year's South Bank exhibition. As for "local materials" we need only instance the extensive use of Italian marble, which was imported together with native craftsmen who alone have the art of revealing its peculiar lustre.

The fact is, of course, that the origin of modern architectural style, which is your correspondent's main bone of contention, was "multifocal"; in Chicago, where Frank

Lloyd Wright built several private houses in the new idiom in the 'nineties, in Dessau in 1907 where Gropius founded his famous *Bauhaus*, in Vienna just after the first world war, and from this point of view the adjective "Scandinavian" is slightly misleading. But it was in the latter countries that the seed firmly took root, was adapted to local climatic conditions (hence the minor differences in the new College Hall, retailed with such beckmesserian delight by your correspondent) and, most important of all, was recognised and encouraged by National and Municipal Authorities in their housing schemes. No doubt all countries can point to isolated examples of modern architecture built for discriminating private patrons, but they can hardly exist anywhere in such officially sponsored profusion and good taste as in Scandinavia.

No one would gainsay the beauty and importance *for this country* of the Festival of Britain Exhibitions, but as a style it is at least forty years old, as many of our Continental friends were quick to remind us last summer. To deny honour where it is due is to reveal the impenetrable ha-has of an artistic chauvinism, conspicuously out of joint with a time when the salving of European culture is vital to our further existence.

We are, Sir,

Yours, etc.,

BURBANK AND BLEISTEIN.

Abernethian Room.

ALPINE CLUB

To the Editor,

St. Bartholomew's Hospital Journal.

Dear Sir,

On reading your contributor's account, one wonders whether in fact, the climbers were in Cumberland or Wales. Even Chesterton could not make the A.6, however much it curled and twisted, reach the mountains of North Wales. The following names and mountains mentioned are not known in the Snowdon region. There is a Bettws-y-Coed, so descriptive of the wooded hollows in which the village shelters; Bettws-y-Loed conveys only the image of the populated clefts of the South Wales mining valleys. The difference is as great as Motherwell and Glencoe. And where is Llewedd, Lliwedd, Crib goch, Glyder, Siabod, Tryfan, Carneddau. Get them right and learn their meanings so that in the comfort of Pen-y-Gwryd or Pen-y-Pass your members may mix the music of chimneys, couloirs and seracs with the ancient mountain and place names of Eryri.

Yours sincerely,

I. G. WILLIAMS.

Radiotherapy Dept.

A BAKER STREET CORRESPONDENCE

The Editor,

St. Bartholomew's Hospital Journal.

Dear Sir,

Your article on "Sherlock Holmes and Dr. Watson at Bart.'s" in the December *Journal* makes a point which gives supporting evidence to a theory which I have long held and which I was able to put forward in a recent B.B.C. Broadcast discussion of the Sherlock Holmes Society of London on "Problems Connected with the Two Retirements of Sherlock Holmes."

What was Sherlock Holmes in fact doing during his two years travelling in Tibet under the name of Sigerson after his supposed death fall over the Reichenbach Falls, and what was his real reason for concealing his escape? Your contributor's article gives substantial grounds for believing that Holmes was connected with Augustus Matthieson, a well-known Bart.'s figure in the 1870's, in research into Opium and its alkaloids. The probability is that during his two years disappearance Holmes was making further investigations along the lines of this early interest.

The very fact of his secrecy would give weight to this opinion. Holmes told Watson that he kept secret his escape after the deadly encounter with Moriarty because he wished to foil the pursuit of Moriarty's followers. But, in fact, they were the only men who knew that he was still alive, for one of them actually witnessed the encounter and endeavoured to complete the attempted murder of Holmes by dropping rocks on him from above as he lay on a ledge above the Falls. Furthermore, his rooms were watched constantly for his return.

From whom, then, did Holmes really wish to conceal the fact that he was alive as opposed to merely concealing the position of his hiding place? I would suggest that it was from Watson himself. The only point on which these two excellent friends had any real divergence of opinion was Holmes' use of drugs. Watson disapproved strongly of this vicious habit and, diffident as he usually was in Holmes' presence, he made his feelings perfectly clear on that score, trying again and again to break Holmes of their hold. But in spite of all, Holmes continued to use both morphine and cocaine. May not the "Bar of Gold" have been an habitual haunt of his? The awkward encounter with Watson recorded in "The Man with the Twisted Lip," which interrupted one of his sessions of addiction, Holmes cleverly accounted for by explaining that he was pursuing a line of enquiry in connection with a case in hand. Holmes could not risk a recurrence of such an embarrassing rencontre. The "Bar of Gold" was becoming too hot for him. What more natural than that he should seize the opportunity once offered of taking up again his former search into the drug and dallying, perhaps, with the possibility of transplanting the Opium Poppy to England? For it was opium he was after. Cocaine does not occur in Tibet but the Opium Poppy grows in profusion. This obviously was the quest which employed the master-mind during those two years.

Again, what of his activities at Montpelier, supposedly in connection with coal-tar derivatives? This seems to be a far-fetched story of Holmes. Why coal-tar derivatives? Such an occupation would have little connection with Holmes' other pursuits as we know them. No, at Montpelier, he was amassing and sifting the knowledge he had acquired in Tibet, and pursuing his opium research. We know now that the synthesis of opium is a costly and unremunerative process—but may not that knowledge be due to the pioneer work of Holmes, probably under an assumed name and characteristically claiming no share of any glory to which his experiments may have entitled him. Regrettably, as with so much of his academic research work, Holmes has left us no records of his findings.

PAT COULSON.

Sherlock Holmes Society of London,
W.1.

To the Editor,
St. Bartholomew's Hospital Journal.

Dear Sir,

In recent issues of the *Journal* we have read of two entirely imaginary (and now almost *legendary*) characters, who, it is pretended, once graced this Hospital. The enthusiasm of the pretenders is such that they now want to put up *plaques* to their heroic couple. It is to be hoped that the Powers-that-be will prevent the rash of such emblems—which has already broken out in Baker Street and at the Criterion—from spreading to the Royal and Ancient. Perhaps the most surprising thing about this "speckled band" of pretenders is that they appear, in other respects, quite normal. When questioned about the latest cures promised by the press (or even about the Loch Ness Monster) they display a suitable incredulity. They are not astounded when told that two and two make four. But their faith in two mythical members of the genus "Private Detective" has no limit.

I write to suggest that it is time to call a halt, and to give honour where honour is due. It is to *one* man that we should raise our plaque at Bart.'s (if raise a plaque we must) and his name is Conan Doyle.

Yours hopefully,

FIAT JUSTITIA.

Abernethian Room.

A REVIEW REVIEWED

To the Editor,
St. Bartholomew's Hospital Journal.

Dear Sir,

I write because, like the Rector of Huckley, I am a lover of accuracy. Readers of the *Journal* expect to be helped in their choice of textbooks by the reviews published; the January issue, by devoting all the available space to one book, hardly does this. Your reviewer tells us that we must buy this book, but he forgets to tell us whether it fulfils the purpose of its conception. He has a lot to say, but he does not tell us whether we can expect to find any word (as long as we know the correct spelling) in the new edition of *The American Illustrated Medical Dictionary*, as we could in the older editions. I take it that it is still so, for I found St. Vitus, lost to sight according to your reviewer, in 30 seconds, under,

"DANCE, St. Vitus', Chorea," where anyone who has taken the trouble to learn to use a dictionary might expect to find the entry. Your reviewer, who is learned enough to know the difference between Calix and Calyx, which I am not, is obviously a Public School man, for he has allowed the surprising mis-statement: "'LESBIANISM. Homosexuality between women.' A bizarre contradiction," to appear in print without bothering to look up Homosexuality (which is NOT derived by any means from the Latin word Hominus). These two mistakes would have been avoided if your reviewer had taken more trouble; it is unfortunate that he did not.

It is not for an English review to poke fun at the spelling of a book designed for the American market; let us be thankful for the inclusion of the English spelling, and for the fact that the book is still available on this side of the Atlantic, and at the original price. The biographical entries may be short (they consist merely of dates and nationality) but surely that is all the space that a DICTIONARY can afford to give them; after all there are larger reference books, but doubtless the innate sloth of your reviewer would discourage their use.

The review would have been more effective if only the last paragraph had been printed. So, I beg you, sir: keep them short and sweet.

I remain, your humble servant,

CEREBUS.

Wimbledon, S.W.19.

ST. BARTHOLOMEW'S HOSPITAL MEDICAL COLLEGE STUDENTS' UNION

Income and Expenditure Account—year ended July 31, 1951.

INCOME

	£	s.	d.
Members' Subscriptions	2848	3	10
Interest on Investments £172 14s. 8d.; Sundry Receipts, e.g., S.U. Ball £11 19s. 7d.; Sale of Refreshments £11; Stationery £141	343	0	7
Contribution by College towards Expenses of Foxbury	646	4	2
Total Income	**3837**	**8**	**7**

EXPENDITURE

	£	s.	d.
(1) Foxbury Athletic Ground:— Wages £879 14s. 1d.; Rates £231 9s. 4d.; Telephone £20 18s. 2d.; Water, Gas, Elect. £76 1s. 11d.; Coal £36 4s. 2d.; Sundries £52 5s. 8d.; Maintenance £198 7s. 6d.; Renewals £237 7s. 11d.	1732	8	9
(2) Hospital and Charterhouse:— Newspapers £79 17s. 8d.; Accountancy £52 12s. 6d.; Wages £22 10s.; Sundries £40 3s. 7d.; Printing and Stationery £203 12s. 7d.; Administrative Salary £100	498	16	4

(3) Clubs and Societies:—

Abernethian Society	29	12	6	Men's Lawn Tennis C.	8	6	3
Athletic Club	118	6	4	Ladies' Lawn Tennis C.	9	5	11
Association Football C.	82	15	6	Photographic Society	5	12	6
Boat Club	129	19	3	Physiological Society	10	0	0
Boxing Club	24	5	1	Rifle Club	35	10	0
Chess Club	2	10	0	Rugby Football Club	401	13	0
Cricket Club	177	12	1	Sailing Club	30	0	0
Dramatic Society	12	18	3	Squash Club	5	0	0
Fencing Club	24	13	0	Swimming Club	27	17	3
Golf Club	24	16	4	U.L.A.U. Affiliation Fees	47	15	6
Men's Hockey Club	116	6	4	Table Tennis Club	7	2	6
Ladies' Hockey Club	54	5	3				
					1386	2	10

(4) Grant to Journal £14 0s. 1d. (less £11 13s. 5d. recoverable from Medical College)	2	6	8
(5) Depreciation £10; Reserve Fund for Equipment £150	160	0	0
Total Expenditure	**3779**	**14**	**7**
Surplus of Income over Expenditure	**57**	**14**	**0**

The Students' Union Income and Expenditure Account shows a small surplus of £57 for last year. The *Journal* made a loss of £14, this being covered by grants from the Medical College and Students' Union. "Round the Fountain" was reprinted during the year and a large stock of copies is now held by the *Journal*. Costs have continued to rise and income has increased slightly with the increased income from the raised S.U. subscription. This increase is not likely to be maintained if there is a smaller entry to the Medical College. Club grants for 1951-52 have been kept at approximately the same amount as last year.

SPORT

GOLF CLUB

In a match played at Sundridge Park G.C., the club beat St. George's Hospital by three matches to one.

The Annual Meeting was held at Sundridge Park G.C. Fiddian and Sleight tied for Dr. Graham's Cup (best scratch score), each with 82. Elliott was third with 84. In the play-off R. V. Fiddian won the cup with a round of 77.

P. Sleight won the Girling Ball Trophy with a 66 (82—16) and the Hospital challenge cup (three up against Bogey). Twelve students competed.

Honours for 1951 have been awarded to R. E. Dreaper and C. J. R. Elliott. Colours were awarded to J. Bowman, B. Deering, J. Dodge, R. E. Dreaper, C. J. R. Elliott, R. V. Fiddian, A. Lodge, P. Sleight, and J. P. Waterhouse.

RUGGER CLUB

January 2, v. Leeds Medicals at Chislehurst. Won 19-8.

Played on a cold, wet day with a very greasy ball, Bart.'s did well to beat this lively touring side, who made up for what they lacked in weight and experience by sheer enthusiasm.

The first half was dull and chiefly notable for the number of chances which Bart.'s missed, largely due to bad handling of the difficult ball. After ten minutes a passing movement along the three-quarter line resulted in Fitzgerald going over in the corner. The kick was missed.

Then the Leeds' right wing, with a fine burst of speed, completely outstripped the home defence to score in the centre. This was converted and with no further scoring the sides changed over with the visitors leading by five points to three.

Soon after the restart Jones kicked a penalty goal to give Bart.'s the lead again. They were not to hold this for long, however, for a determined run along the touchline by the Leeds left wing enabled him to score in the corner. The difficult kick was missed, and with Bart.'s once again two points down the whole side suddenly woke up. They attacked immediately and a break-away by Davies was well backed up by Third, who, showing a turn of speed remarkable for one so heavy, crashed over for a fine try which he promptly converted. Next, a rush by the whole pack resulted in one of them touching down. The kick was missed. Finally, Davies, with a neat kick ahead, beat the full back to score a grand try which Third converted. Bart.'s kept up the pressure until the whistle went for no side.

Outstanding in the pack were Gawne, Third and Havard, while Mackay and Davies were the pick of the backs.

This second half display was most encouraging. After losing the lead twice, the team fought back and it is this spirit which will be so much needed for the stern battles which lie ahead.

January 12, v. Cheltenham. Lost 0-3.

Cheltenham scored a very quick try near the corner flag from one of the few three-quarter movements seen during the afternoon. The game soon developed into a very hard forward battle and remained as such until the final whistle. The visitors were loath to open up the game, and were able to dictate the play by preventing the Bart.'s forwards from feeding their backs. Consequently, the home three-quarter line had few opportunities and were not able to penetrate the Cheltenham defence.

Davies very nearly equalised in the second half with a drop shot which rebounded from the crossbar. The defensive, spoiling play of the Bart.'s back row was excellent, and unfortunately necessary when lack of possession became the rule.

Team: B. N. Foy, A. D. M. Thomas, J. M. Kneebone, M. J. A. Davies, J. K. Murphy, G. Scott Brown, B. Grant, A. J. Gray, P. Knipe, A. J. Third, J. Jones, W. B. Castle, L. Cohen, E. Gawne, C. W. H. Havard (Capt.).

SWIMMING CLUB

Although one of the hospital's smallest clubs, the Swimming Club has been one of its most successful in its matches over the past twelve months. Nine matches have been won, three drawn, and four lost; goals for being 76 and goals against 59. Scorers were: Low, 8; Cohen, 20; Bliss, 39.

In the Inter-Collegiate League for 1951 Bart.'s finished second to L.S.E. in their league; an appreciable achievement, as the only practice available was in the matches themselves. At the end of the season colours were awarded to: F. Low, L. Cohen, M. H. Graham, and P. Bliss.

During the late summer water polo activity subsided with the Charterhouse recess, but it brought news of the award of University of London colours for water polo to L. Cohen and P. Bliss. October saw the beginning of the first post-war Inter-Hospitals league. After a shaky start Bart.'s played more decisive polo and, after losing to St. Thomas's and twice to St. Mary's, won all their other matches to finish second to St. Mary's.

We congratulate Lester Cohen on being elected Captain of the United Hospitals' Swimming Club for 1952—the first captain since 1938 to come from Bart.'s.

Finally, once again the appeal goes out for new players and swimmers, for the club cannot hope to increase their successes relying only on the eight faithfuls!

WOMEN'S LAWN TENNIS CLUB

At the Annual General Meeting held on November 6th the following Officers were elected for the coming season:—

Captain—Margaret Robinson;
Vice-Captain—Jean Cree;
Hon. Sec. and Treas.—Marguerite Smith;
Pre-clinical representative—Sheila Balhatchet.

It was decided to arrange fixtures for two teams to play matches next summer, and it is hoped that there will be increased support for the club during the season. Practice games will be held during April, probably at Paddington Recreation ground.

A silver cup has been bought, to be awarded annually for the winner of the Women's Open Singles tournament. This was won last year by M. Robinson.

SO TO SPEAK . . .

Making it clear :

" Physical signs in the chest were regarded as having cleared when either (1) there were no residual physical signs. . . ."

. . . *or* (2) *they had cleared?*

" All appointments are effective from July 1st each year . . . other appointments are not on any specified date."

—a hospital prospectus.

A final year student was overheard to say that he was not trying to fill the gaps in his knowledge, but to create a few in his ignorance.

". . . it is normally necessary to kill a mouse since it can be identified by its ability—

1. To ferment Inulin ;
2. It is soluble in Bile."

—A Candidate.

BOOK REVIEWS

SIXTEENTH-CENTURY SURGERY

Ambroise Paré is a name unknown, heard of, and well known by members of the medical profession. His works come mostly in the second of these categories. The Falcon Educational Books are to be congratulated for their attempt to remedy this situation by the publication of " The Apologie and Treatise of Ambroise Paré, containing the voyages made into Divers Places "—a volume which includes many of Paré's other writings upon surgery.*

Paré was a French surgeon who lived from 1510 to 1590, and achieved great distinction, being for many years the " premier Chirurgeon du Roy." His writings contained in this book are taken from two separate sources : one—the Apologie and Treatise—is complete ; the other, from his surgical writings, is a selection made especially for this edition. The English text here used is that of an edition of Paré's collected works published in London in 1634. A prospective buyer should by no means be put off by this period English, for the translation is admirable, and often lends colour to Paré's forthright style.

The present edition opens with the Apologie and Treatise, which comprises a little less than half the book. This part was written by Paré at the age of seventy-five. Far from being an old man's reminiscences, it is an enthralling and detailed account of his many journeys with the French Army and of his capture by the Spaniards, and opens with the Apologie—the author's defence of his own surgical methods. This defence is especially of his use of the ligature in staunching bleeding. His adversary in the matter—one Gourmelen—advocates the use of the traditional cautery. Paré scarcely mentions Gourmelen by name, but scornfully addresses him as " mon petit maitre," and denounces his methods as those of the bookworm with no practical experience. For—

" To talke's not all in Chirurgeon's Art,
But working with the hands."

—as Paré reminds him. Paré has no hesitation in telling the reader of his own wide experience, but does so in such highly diverting prose that he seems not egotistical at all. Only once in the Treatise of his experiences does he give us a glimpse of the age of the writer. He gives a description of how he obtained a receipt from a surgeon of Turin " by gifts and presents," but in one of his earlier writings (later in this volume) he describes the same incident slightly differently : he got the prescription because he was returning to Paris where he could not be a rival in practice.

The writings upon surgery have not quite the immediate attraction of the Apologie and Treatise, but they contain much of interest, and are not to be decried for they are the thoughtful writings of a man of intelligence and wide experience. The basis of so much modern surgical thought is contained in Paré's writings that it is not surprising that he could cure when his colleagues could not. " Yet none," wrote Paré, " must thinke to attaine to any great perfection in this Art, without the help of the other two parts of Physicke ; I say

* The Apologie and Treatise of Ambroise Paré, edited, and Introduction, by Geoffrey Keynes. First edition, 1951. Falcon Educational Books, Ltd., pp. 220. Illustrated. Index. Price 15s.

of Diet and Pharmacie. . . . " Advice which is sometimes forgotten even to-day.

Paré shows throughout the book that he is a cultured man, and one of a becoming humility (except where Gourmelen is concerned). He mixes freely with the nobility of France and is so highly thought of that he is sent from one nobleman to another to execute their cures. This humility is well shown by his oft-repeated remark, "I dressed him, and God healed him." How much of the humour that may be found in these pages is unintentional is difficult to judge. Some may be Paré's, some the translator's, and other the reader's. To whichever it is due, the humour of ascribing congenital malformations to the "imbecilitie of the forming facultie" cannot be denied.

Some of the terms used in the translation (few are Latin) need explanation, and in most cases this is given in footnotes. In two places the footnote does not correspond with the first use of a word, but this is a minor criticism. It is excellent that these notes have been kept so brief and few in number. Footnotes climbing half up the page can so easily spoil a book of this type.

This book is the first of a new Series, it is exceptionally well produced, and the price is low. Paré is a neglected subject, but does not deserve to be so. This is a book to read, and keep, and read again.

DR. VIPER, THE QUERULOUS LIFE OF DR. PHILIP THICKNESSE, by Philip Gosse. Cassell & Co., 1951, pp. 332 + 7 half-tone illustrations. Price 21s.

In his biography of the querulous life of Philip Thicknesse, Dr. Gosse has discovered not only the curious character of his eccentric eighteenth-century hero, but he has also dug up a gallimaufry of dross, gossip and skulduggery. Promising material? No! But in Dr. Gosse's hands, hands that are experienced with travellers' tales and pirate yarns, he spins a fascinating tale. Browsing through the D.N.B., Dr. Gosse comes across "that most gentle, lovable poet and physician, and inventor of the famous biscuit, Dr. William Oliver of Bath," who had a quarrel but once, and that with Philip Thicknesse. Turning up Thicknesse and finding him, between **Teach** and **Tollett,** described as the "Lieutenant-Governor of Languard Fort," Dr. Gosse has gone on to unravel for us the whole life story of this adventurer, writer, snob, leech, columnist, laudanum addict, rustic gardener—a Shirley Hibberd of an earlier age—who travelled widely and met with everyone who was anyone, and quarrelled with each in turn. But a surfeit of scandal cloys, and gossip about those for whom we bear no respect is tedious, and it is perhaps a pity that Dr. Gosse has not told us more of Thicknesse's contemporaries and how such an eccentric managed to find a place in the orthodox eighteenth century we know. This is a book which must have been fun to write—it is certainly entertaining to read.

ANAESTHETICS FOR MEDICAL STUDENTS. Gordon Ostlere. 2nd Edition. Churchill, pp. 108. Price 8s. 6d.

This is a textbook for the pocket of every medical student, for in a very clear and readable manner Dr. Ostlere gives a practical approach to the commoner anaesthetics and how to give them. There are some changes from the first edition, but the joys of the Author's conversational style remain. This is a book without frills, there are no long explanations of the mode of action of the various drugs, that is for a larger book; the aim of this book is to enable the student to approach anaesthetics knowing the essentials of how to give a safe anaesthetic, and its possible dangers; in this it succeeds admirably.

THE PRACTICE OF ENDOCRINOLOGY. Edited by Raymond Greene. Revised Edition. *The Practitioner Series.* Eyre and Spottiswoode, 1951. (Pages 389 + xxiii. 56 illustrations). Price 65s.

This book is one of the most successful in *The Practitioner Series.* It is written for the General Practitioner and therefore wisely concerns itself more with the practical matters of diagnosis and treatment than the theoretical aspect. The revised edition has taken this a step further, and the more academic chapters have been pruned, though not completely, and there are one or two (one could wish for more) illustrations of historical dwarfs and adrenogenital saints, but why is there no reference to these in the text? A fruitless visit to St. Paul's and an afternoon in the B.M. Reading Room were necessary to discover the full and interesting story of St. Uncumber. Dr. Greene writes clearly and the reading is so easy as to be a pleasure; it is beautifully produced and authoritative, but is unfortunately marred by a number of misprints or mistakes, though an Errata is now available.

GYNAECOLOGICAL ENDOCRINOLOGY FOR THE PRACTITIONER, by P. M. F. Bishop. 2nd Edition, 1951. Livingstone, pp.ix + 132, figs. 16. Price 12s.

This excellent little book is meant primarily for the general practitioner. It seeks to give him a clear and up-to-date picture of endocrine physiology as it affects the female subject and to point out how the normal processes may be disturbed. Its aim is essentially practical and controversial theorising has no place in the book. Practitioners will be especially grateful to Dr. Bishop for his clear exposition of modern hormone therapy. He gives a fair assessment of the place of such therapy and does not minimise its limitations or the dangers of its misuse. He condemns random empirical therapy.

The book is well arranged and easy of reference. Although intended for the practitioner it will be welcomed too by students, both pre- and post-graduate, as a successful attempt to extract the essentials from a complex subject and to present them in a lucid, even if somewhat dogmatic manner.

In this edition the text has been revised and a new self-contained chapter on steroid chemistry has been added for the benefit of those readers who wish to know a little more about these substances which he usually finds cloaked in such a multitude of names.

TREATMENT BY MANIPULATION, by H. Jackson Burrows and W. D. Coltart. Enlarged Edition. *The Practitioner Series.* Eyre and Spottiswoode. 1951, pp. 80.

This book, which follows the first edition by eleven years, like the first is well produced, being reminiscent of a slim volume of privately printed poems. It is divided into two sections; the first describes selection, diagnosis and management together with some warnings; the second describes with numerous illustrations, in which appear a pair of powerful and vaguely familiar arms, the technique of the manipulations. This is a timely book and one that makes the better aspects of the bonesetters' craft respectable.

CLINICAL PATHOLOGY DATA by C. J. Dickinson. Blackwell, 1951, pp. 32. Price 4s. 6d.

Sitting in the front row of M.O.P.'s and at a loss for the normal blood urea, any student would be very grateful for this booklet—his house job would be assured. All the normal figures of body fluid constituents are clearly listed, the diseases causing variations are noted, and even some of the tests are explained. This information takes time to disentangle from a text-book, but is here most easily—and accurately—obtainable.

Any student who approached the final examination without this booklet would be seriously failing in his duty to himself—and possibly his examiners!

AN INTRODUCTION TO MEDICINE FOR NURSES. 2nd Edition, 1951. By Patria Asher, M.D., M.R.C.P., pp. 354. William Heinemann. Price 25s.

This new edition is actually sixty pages shorter than its predecessor, in spite of the addition of a great deal of new material. This is achieved by abandoning the wide margins of the old edition and by judicious pruning. Some more illustrations are added, and those in the new chapter on children's diseases are especially good. One of the attractions of Dr. Asher's book is its presentation of cases as patients, and its conversational style. This unfortunately leads to such lapses as "The liver recklessly adds to the confusion by breaking down protein. . . ." The glossary might well be dispensed with; the nurse who reads this book knows the meaning of nerve, fever, fracture and tumour. The price must now be at the limit of what the student nurse can afford, but it is the most modern medical text-book she can get, and can be well recommended.

SELECTED WRITINGS OF SIR WILLIAM OSLER, with an introduction by Geoffrey Keynes (pp. 279 + 5 illustrations), Oxford University Press. Price 15s.

This selection of writings, which has been made by a committee of the Osler Club, was published to celebrate the fiftieth anniversary of Osler's birth. They have made a good choice from such a wide field. There are several biographical essays, philosophical writings and letters, together with *Illustrations of the Bookworm.* No hospital in Britain had closer associations with Osler than did Bart.'s. He was frequently invited to the Hospital, he addressed the Abernethian Society, and has had a considerable influence on various members of the staff. It is pleasant, therefore, to find Dr. Franklin as the editor and Mr. Geoffrey Keynes writing the introduction, which, for many, will be the most enjoyable and profitable part of the book.

MODERN DIETARY TREATMENT by M. Abrahams and E. M. Widdowson, pp. viii, 356. Baillère Tindall and Cox, 3rd edition. Price 21s.

The third edition of this well-known book is well up to the standard of the first two, and is in many ways better. The old scheme of dividing the diets, which the second half of the book contains, by price, into separate grades has been abandoned. One can almost hear the late Minister of Health chuckling over this evidence of Socialism at work, while he fills up his Super Tax returns. The simplicity which has been gained is greatly to the advantage of the book, and the multifarious diets are more readily understood. The first half of the book is concerned with the general principles of both the normal and special diets—this part may be recommended to the student—the remainder is a detailed account of the constitution of special diets and can only be recommended to those dieticians, nurses and doctors who have actually to arrange the details of a diet; and to them this book will be, as always, invaluable.

THE BAILY FAMILY of Thatcham and later of Speen and Newbury all in the County of Berkshire, by L. G. H. Horton-Smith. W. Thornley & Sons, 1951, pp. 385. Price £2 2s.

This privately printed genealogical study of the Baily family is lavishly produced, and contains a wealth of material for those interested in the family history. Much personal information of an irritating nature is included, and the final paginated leaves advertise the compiler's other writings.

The work is of interest to us for several reasons. The story of the Baily family commences with Dr. Walter Baily (1529-1592), Physician to Queen Elizabeth, and several of the persons mentioned were medical men. Among these is Sir Percival Horton-Smith Hartley, Consulting Physician to this Hospital, and brother of the compiler of this volume. The book is conspicuous for the generous detail presented, for a lengthy pedigree, and a host of blank pages, presumably for annotations.

MARRIAGE, by Kenneth Walker, pp. 136 + XII. Martin Secker and Warburg, Ltd., 8s. 6d.

WOMAN: HER CHANGE OF LIFE, by Miriam Lincoln, pp. 116. Williams and Norgate, Ltd., 6s.

ADVICE TO THE EXPECTANT MOTHER ON THE CARE OF HER HEALTH, pp. 50. E. and S. Livingstone, Ltd., 9th Edition.

Under review are three books which the medical practitioner may care to recommend to patients—each admirably dealing with a particular problem.

Kenneth Walker's book is intended for the "married and the about to be married." This latter important group has been rather neglected as far as ethical literature is concerned, though there is a profusion of pseudo-scientific works dealing with their problems. The author considers the place of marriage and sexuality in modern society before discussing marriage preparation, reproduction, family planning and—most important—"contributory causes to failure in marriage." No one will be in complete agreement with all that the author says—the final chapter on premarital chastity will be the most controversial!—but throughout one is struck by the logical approach and cannot fail to admire the insight which this accords. The practitioner will do well to read this book himself.

Miriam Lincoln has written a little gem of a book which may well be recommended to those many women who are worried about the approaching menopause. She has a happy knack of presentation which in itself allays the fear complex so often present. Perhaps the most important chapter is entitled "Warning Signals Suggestive of Cancer"—Cancer Education as it should be.

F. J. Browne's little pamphlet is in its ninth edition—a fact which speaks for itself. For it we have little but praise, but what a pity that it still reads: "The following is a modified list of baby clothes suitable for use during war-time restrictions. The number of coupons required is given."

QUININE, QUINIDINE and other cinchona alkaloids in Clinical Practice. The London Cinchona Bureau. Director, Sir Philip Manson-Bahr.

This 28-page pamphlet summarises the use of the cinchona alkaloids, together with routes of administration and dosage. The subjects covered range from malaria and auricular fibrillation to the treatment of hydrocele. In this latter condition, treated by sclerosing agents, not all would agree that "the results of this treatment are at least as good as, and probably superior to, the results of operation." A list of references are given. Copies are available on request at 10, Princes Street, S.W.1.

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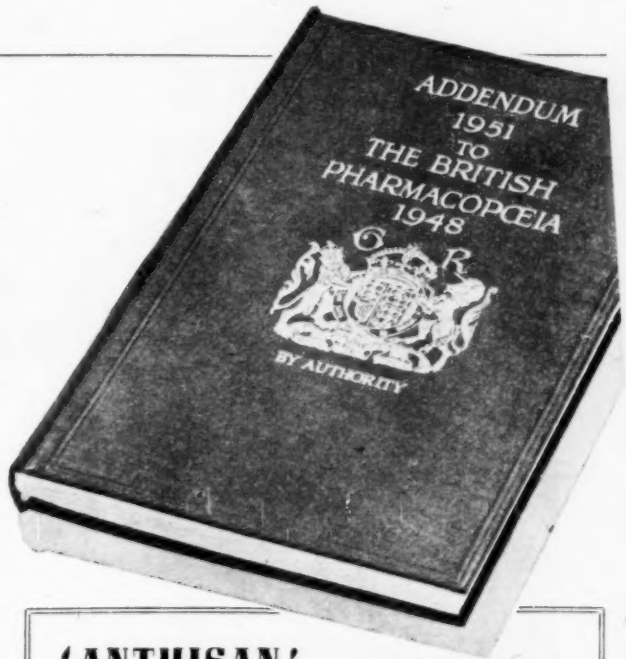

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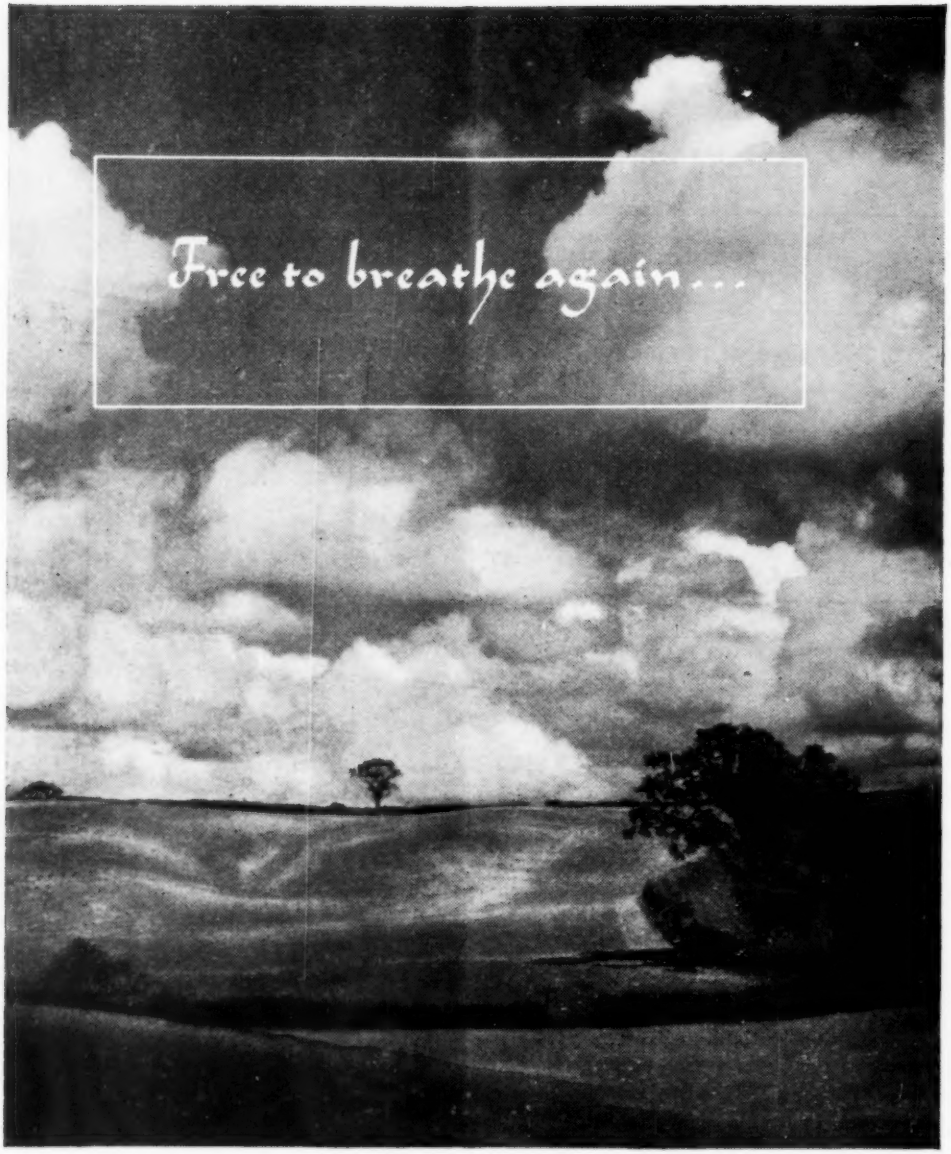

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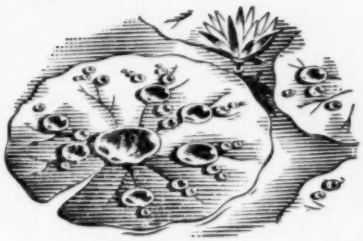

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